STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152522	A. BUILDING _____ B. WING _____	R 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPREHENSIVE RENAL CARE - HAMMOND	**222 DOUGLAS ST HAMMOND, IN 46320**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS This visit was a revisit for an ESRD Recertification Survey completed on 4/29/13, 4/30/13, 5/1/13, 5/2/13, and 5/3/13. Survey date: 6-12-13 Facility: 005981 Medicaid Vendor: 100147640B Surveyor: Bridget Boston, RN, PHNS Five (5) conditions and twenty-three (23) standard level deficiencies were found corrected during this survey. Comprehensive Renal Care-Hammond was found to be in compliance with the Conditions for Certifications for ESRD facilities 42 CFR Part 494. Quality Review: Joyce Elder, MSN, BSN, RN June 14, 2013	{V 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.